STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLE				
		155135	B. WIN			01/18/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	DDRESS, CITY, STATE, ZIP CODE		
					INIC DR		
WESTVI	EW NURSING AND	REHABILITATION CENTER		BEDFO	RD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	·	ICY MUST BE PRECEDED BY FULL		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	TE	COMPLETION DATE
F0000	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	BEIGER(1)		DATE
1 0000							
	This visit was for t	the Investigation of	F00	00			
	Complaint IN0012	_					
	Complaint 11400 12	.2120.					
	This visit was inco	onjuction to the					
	Recertification and						
		d Otate Electionic					
	Survey.						
	Complaint IN0012	22128 -					
	Substantiated. Fe						
		ed to the allegations					
	are cited at F225	_					
	are cited at F225	and F220.					
	Survey Dates:						
	January 07, 08, 0	0 10 11 14 15					
	Ī						
	16, 17, and 18, 20	JIS					
	Facility number: (000060					
	Provider number:						
	AIM number: 100						
	7 divi ridiniber. 100	720000					
	Survey team:						
	Susan Worsham,	RN-TC					
	Sharon Whiteman						
	Kimberly Perigo,	,					
		1/16/12)					
	RN(1/7/13,1/8/13,	, 1/ 10/13)					
	Conque had tura						
	Census bed type:						
	SNF/NF: 73						
LABORATOR	LY DIRECTOR'S OR PRO	VIDER/SUPPLIER REPRESENTATIVE'S SI	GNATURI	<u>I</u>	TITLE		(X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

URRA11

Facility ID:

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2013 FORM APPROVED OMB NO. 0938-0391

	of correction identification number: 155135	A. BUILDING	00	COMPLETED 01/18/2013
	100100	B. WING	ADDRESS, CITY, STATE, ZIP CODE	0 17 10/2010
NAME OF F	ROVIDER OR SUPPLIER		LINIC DR	
WESTVII	EW NURSING AND REHABILITATION CENTER	BEDFO	PRD, IN 47421	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES	PROVIDER'S PLA		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	COMPLETION DATE
	Total: 73			
	Census payor type:			
	Medicare: 12			
	Medicaid: 53			
	Other: 8			
	Total: 73			
	These deficiencies reflect state			
	findings cited in accordance with 410			
	IAC 16.2.			
	Quality Review completed on January			
	29, 2013; by Kimberly Perigo, RN.			

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: URRA11

Facility ID: 000060

If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY				
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUILDING	00	COMPLETED	
		155135	B. WING		01/18/2013	
NAME OF T	DOLUDED OF GURDLES		STREET.	ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER		1510 C	LINIC DR		
	EW NURSING AND	REHABILITATION CENTER		ORD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX	*	CY MUST BE PRECEDED BY FULL	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA		
TAG		LSC IDENTIFYING INFORMATION)	TAG	DEFICIENCY)	DATE	
F0225	483.13(c)(1)(ii)-(ii					
SS=D	INVESTIGATE/R					
	ALLEGATIONS/II					
	have been found	not employ individuals who				
		streating residents by a				
	•	ave had a finding entered				
		se aide registry concerning				
		nistreatment of residents or				
		of their property; and report				
		has of actions by a court of				
	•	nployee, which would				
		for service as a nurse aide				
	registry or licensi	aff to the State nurse aide				
	registry of licerisii	ng authornies.				
	The facility must	ensure that all alleged				
	_	ig mistreatment, neglect, or				
		njuries of unknown source				
	and misappropria	tion of resident property				
	are reported imm					
		ne facility and to other				
		ance with State law				
		ed procedures (including to and certification agency).				
	the State survey a	and certification agency).				
	The facility must l	have evidence that all				
	alleged violations					
	•	must prevent further				
	potential abuse w	hile the investigation is in				
	progress.					
	The see 10 16 10					
		investigations must be				
	reported to the ac	sentative and to other				
		ance with State law				
	(including to the S					
	,	cy) within 5 working days of				
		if the alleged violation is				
	verified appropria	te corrective action must				
	be taken.					
	Based on record r	review and interview	F0225	What corrective action(s) wi	02/11/2013	

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Event ID: URRA11

Facility ID: 000060

If continuation sheet

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135			ULTIPLE CO LDING	00	(X3) DATE SURVEY COMPLETED	
		155135	B. WIN	IG		01/18/2013
	PROVIDER OR SUPPLIER	REHABILITATION CENTER		1510 C	ADDRESS, CITY, STATE, ZIP CODE LINIC DR DRD, IN 47421	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
PREFIX	the facility failed to staff thoroughly in reported an allegathe Administrator as indicated by the procedures for 1 coreviewed for resident (a). Findings Include: During review of the reportable occurrence dated noted, "Employee FormNurse (Nuam to help CNA # (Resident #C) up observed resident incontinent pad. [#1)was called into	cy Must be preceded by full also investigated and ation of neglect to and other officials eir policy and of 3 residents lent care. (Resident lent care) (Res		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION DATE COMPLETION DATE Completion of the second
	at that time 2n that multiple peop	ll trays were left in			Administrator/DNS. All staff will be in-service on abuse/neglect including who constitutes abuse/neglect, to whom to report abuse and who his/her responsibility upon witnessing abuse/neglect, by	en,
	charge nurse/shift	t supervisors"			2/11/13 by the SDC/designee	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIII	A. BUILDING COMPLETED		
		155135	B. WIN			01/18/2013
					ADDRESS, CITY, STATE, ZIP CODE	
NAME OF F	PROVIDER OR SUPPLIER	t .		1510 CI	LINIC DR	
WESTVII	EW NURSING AND	REHABILITATION CENTER		BEDFO	RD, IN 47421	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG		· · · · · · · · · · · · · · · · · · ·		TAG	will be in-serviced prior to their	DATE
Written in different handwriting underneath this section was, "On Sat				next scheduled shift by the		
					SDC/Designee. Non-compliance with the	256
	[Saturday] 9-15-1	·			procedures will result in further	
		sidents in this CNA's			education including disciplinar	y
	(CNA#2's)section				action. Administrator/DNS are	
	_	brown rings under was check marked			responsible to ensure	
					compliance.	
	at, "Final Written \	warning.			What measures will be put in	to
	Interview of the DON [Director of Nursing] on 01/17/13 at 8:16 a.m.,				place or what systemic	
					changes will be made to	
					ensure that the deficient	
	indicated the DON	Nhad written on the			practice does not recur?	
	bottom section of	the Employee			· All allegations of	
	Communication F	orm what was			abuse/neglect will be reported the Administrator/DNS	to
	reported to her by	Nurse #1.			immediately and to the resider	nts
					representative within 24 hours	•
	Interview of Nurse	e #1 on 01/17/13 at			report. All allegations of	
	7:46 a.m., indicate	ed CNA #2 was the			abuse/neglect will be investiga	ited
	CNA assigned to	Resident #C on			including interviewing all staff	
	09/14/12 . Nurse	#1 indicated she			involved, to assure all policies and procedures are followed b	y
	went in with an ur	nassigned CNA			the Administrator/DNS.	
	sometime before	lunch (but didn't			All abuse/neglect allegations will be reported to to	the
	remember the CN	IA's name) to pull			ISDH within 24 hours by the	
	resident #C up in	bed and saw that			Administrator/DNS. All staff will be in-service	-d
	his gown was soil	ed and had BM on			on abuse/neglect including wh	
	his bed pad. Nurs	se #1 indicated she			constitutes abuse/neglect, to whom to report abuse/neglect	
	had asked CNA #	2 to change the			and when, his/her responsibilit	
	resident's bed pad	d and gown and she			upon witnessing abuse/neglec	
	(CNA #2)said she	would. Nurse #1			by 2/11/13 by the SDC/design post test included. Any PRN s	
	indicated this was	before lunch.			will be in-serviced prior to their	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY					
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155135	A. BUIL	DING	00	COMPLETED 01/18/2013	
		193133	B. WING		DDDDGG GYRY GELER GYD GODD	01/16/2013	
NAME OF I	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE LINIC DR		
WESTVI	EW NURSING AND	REHABILITATION CENTER			RD, IN 47421		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	,	(5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)		PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)	E COMPL DAT	
	Nurse #1 indicated that evening shift had called her in at shift change to				next scheduled shift by the SDC/Designee.		
					Non-compliance with the	ese	
	report there was s	till BM on Resident			procedures will result in further		
	#C's bed pad. Nu	rse #1 indicated			education including disciplinary action.	′	
	she didn't rememb	per who the evening			· Administrator/DNS are		
	shift nurse was. N	Nurse #1 indicated			responsible to ensure compliance.		
	that CNA #2 denie	ed leaving the			отпріїапос.		
	resident on a soile	ed pad. Nurse #1			How the corrective action(s)		
	indicated evening	shift CNA's had			will be maintained to ensure the deficient practice will not		
	reported to her that	at they had found			recur, i.e., what quality		
	sheets soiled with	led with brown rings during			assurance program will be pu	ıt	
	bed checks at the	start of the evening			into place?		
	shift and they had	changed the			· The CQI tool for abuse staff		
	sheets. Nurse #1	indicated she put a			interview and abuse prohibition and		
	note under the DC	DN's door to inform			investigation will be utilized weekly		
	the DON of the all	egation. Nurse #1		x4, and monthly x6 • Findings from the CQI process		s	
	indicated she did	not go to look at the			will be reviewed monthly and an		
	soiled sheets, but	she did believe			action plan will be implemented for threshold below 95%.		
	what the CNA's to	ld her. Nurse #1			threshold below 95%.		
	indicated the CNA	s's reported they had					
	found brown rings	on Resident #C's					
	sheet						
		The DON was interviewed on					
		01/17/13 at 08:16 a.m. The DON					
		indicated the					
	all	egation occurred on a Friday and					
	she	was not made aware of it until the					
	follo	wing Monday. The DON indicated					
		she was made aware of the					

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Event ID: URRA11

Facility ID: 000060

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	OF CORRECTION IDENTIFICATION NUMBER:	(X2) MULTIPLE CO A. BUILDING	00	COMPLETED	
	155135	B. WING 01/18/2013			
	PROVIDER OR SUPPLIER EW NURSING AND REHABILITATION CENTER	1510 CI	ADDRESS, CITY, STATE, ZIP CODE LINIC DR RD, IN 47421	_	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD I CROSS-REFERENCED TO THE APPROF DEFICIENCY)	BE COMPLETION	
	allegations by an "Employee				
	Communication Form." The DON				
	indicated she questioned Nurse #1				
	and Nurse #1 had reported to her that				
	she didn't see the brown rings but				
	second shift had reported it to her.				
	The DON indicated Nurse #1 had told				
	her (the DON) that the second shift				
	aides had reported dried rings on				
	resident sheets to her (Nurse #1) but				
	they (the evening shift CNAs) had				
	changed the soiled sheets. The DON				
	indicated she didn't remember if she				
	had ask who the evening shift CNA's				
	were who made the allegations and				
	the CNA's were not interviewed. The				
	DON indicated she did discuss the				
	allegations with CNA #2 and she				
	became, "kinda of insubordinate at				
	the time because she felt like she was				
	being picked on." The "Employee				
	Communication Form indicated CNA				
	#2 had refused to sign the form." The				
	DON provided Resident #C's				
	Progress Note dated 09/14/12 at 1:36				
	p.m., which indicated, "Area to coccyx				
	resolved at this time. Area healed.				
	Scar tissue remains." This Note was				
	signed by the ADON. The Director of				
	Nursing further indicated, the				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135		(X2) MU A. BUIL B. WINC	DING	NSTRUCTION 00	(X3) DATE COMPL 01/18/	ETED	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	B. WINC	STREET A	LINIC DR RD, IN 47421	1	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	1	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPR DEFICIENCY)	IATE	(X5) COMPLETION DATE
	į į	reported to the Indiana State					
	o1/14/13 at 10:00 indicated, "It is the Senior Communit residents from abi includingnegled when facility staff and/or supervise t resident care and that care is provid the residents. Ne facility fails to provifor resident, such which residents at urine or fecesA allegations/abuse the Executive Dire and to the resident within 24 hours of to report will result action, up to and it terminationIt is the Administrator/	vestigation (not ed by the DON on a.m. The policy e policy of American ties to protect use etNeglect occurs fails to monitor the delivery of services to assure ed as needed by glect occurs when a vide necessary care as situations in re being left to lie in Il abuse must be reported to ector immediately, it's representative the report. Failure					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/18/2013
FORM APPROVED
OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155135	(X2) MULTIPLE CO A. BUILDING B. WING	00	COM	e survey pleted 8/2013
	PROVIDER OR SUPPLIER EW NURSING AND REHABILITATION CENTER	1510 C	ADDRESS, CITY, STATE, ZIP C LINIC DR PRD, IN 47421	CODE	
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION SI CROSS-REFERENCED TO THE A DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	abuse, within 24 hours to the Indiana State Department of Health"				
	This Federal/state tag is relates to Complaint IN00122128.				
	3.1-28(c) 3.1-28(d)				

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STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY A. BUILDING 00 COMPLETED B. WING 01/18/2013			ETED		
	PROVIDER OR SUPPLIEF	REHABILITATION CENTER		1510 CL	ADDRESS, CITY, STATE, ZIP CODE LINIC DR RD, IN 47421		
(X4) ID PREFIX TAG	FIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL		P	ID REFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETION DATE
F0226 SS=D	ETC POLICIES The facility must written policies an mistreatment, ne residents and mis property.		F022	6	What corrective action(s) will be accomplished for those residents found to have beer		02/11/2013
	procedures for 1 or reviewed for alleg resident care. (Re	of 3 residents ed neglect of			affected by the deficient practice? Resident C did not have negative outcome related to the alleged deficient practice	e	
	at 11:00 a.m., the occurrence dated noted, "Employee FormNurse (Nu am to help CNA # (Resident #C) up observed resident incontinent pad. I #1)was called into see resident sittin dirty gown. Nurs unassigned CNA	following 09/14/12, was Communication urse #1) went in this 2 pull resident in bed. Nurse t had BM on Nurse (Nurse o room after lunch to g in same BM and			How other residents having to potential to be affected by the same deficient practice will be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. All allegations of abuse/neglect will be reported the Administrator/DNS immediately and to the resider representative within 24 hours report. All allegations of abuse/neglect will be investigatincluding interviewing all staff involved, to assure all policies and procedures are followed by the Administrator/DNS. All abuse/neglect allegations will be reported to a sure allegations will be a sure allegations and a sure allegations and a sure allegations are allegations and a sur	e de	

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A BIII	A. BUILDING COMPLETED			
		155135	B. WING 01/18/2013				
NAME OF E	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
					LINIC DR		
WESTVIEW NURSING AND REHABILITATION CENTER			BEDFORD, IN 47421				
(X4) ID		SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIATE	TE COMPLETION DATE	
TAG				TAG	ISDH within 24 hours by the	DATE	
	that multiple people were left unchangedHall trays were left in				Administrator/DNS.		
		Ť			 All staff will be in-service on abuse/neglect including wh 		
	rooms/insubordina				constitutes abuse/neglect, to	at	
	charge nurse/shift	•			whom to report abuse and who	en,	
	Written in differen	-			his/her responsibility upon witnessing abuse/neglect, by		
		ection was, "On Sat			2/11/13 by the SDC/designee,		
	[Saturday] 9-15-1	•			post test included. Any PRN s will be in-serviced prior to their		
	, .	sidents in this CNA's			next scheduled shift by the		
	(CNA#2's)section	` '			SDC/Designee.		
		brown rings under			 Non-compliance with the procedures will result in furthe 	• • • • • • • • • • • • • • • • • • •	
		was check marked			education including disciplinar		
	at, "Final Written \	Warning."			action.		
					· Administrator/DNS are responsible to ensure		
	Interview of the D	ON [Director of			compliance.		
	Nursing] on 01/17	7/13 at 8:16 a.m.,			M/hat massaums will be mut im	40	
	indicated the DON	N had written on the			What measures will be put in place or what systemic	to	
	bottom section of	the Employee			changes will be made to		
	Communication F	orm what was			ensure that the deficient		
	reported to her by	Nurse #1.			practice does not recur?		
					· All allegations of		
	Interview of Nurse	e #1 on 01/17/13 at			abuse/neglect will be reported the Administrator/DNS	to	
	7:46 a.m., indicate	ed CNA #2 was the			immediately and to the resider	nts	
	CNA assigned to	Resident #C on			representative within 24 hours	of	
	09/14/12 . Nurse	#1 indicated she			report. All allegations of		
	went in with an ur	nassigned CNA			abuse/neglect will be investiga	ited	
	sometime before	lunch (but didn't			including interviewing all staff involved, to assure all policies		
	remember the CN	IA's name) to pull			and procedures are followed b	• • • • • • • • • • • • • • • • • • •	
	resident #C up in	bed and saw that			the Administrator/DNS.		
	his gown was soil	ed and had BM on			All abuse/neglect allegations will be reported to	the	
	his bed pad. Nurs	se #1 indicated she			ISDH within 24 hours by the		

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155135			BUILDING 00 COMPLETE		(X3) DATE SURVEY COMPLETED 01/18/2013	
	PROVIDER OR SUPPLIER	REHABILITATION CENTER	D. WIIV	STREET A	ADDRESS, CITY, STATE, ZIP CODE LINIC DR PRD, IN 47421	
(X4) ID PREFIX TAG	SUMMARY S' (EACH DEFICIEN REGULATORY OR had asked CNA # resident's bed pac (CNA #2)said she indicated this was Nurse #1 indicate had called her in a report there was s #C's bed pad. Nu she didn't rememble shift nurse was. N that CNA #2 denice resident on a soile indicated evening reported to her that sheets soiled with bed checks at the shift and they had sheets. Nurse #1	TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION) 2 to change the d and gown and she would. Nurse #1 before lunch. d that evening shift at shift change to still BM on Resident arse #1 indicated ber who the evening Nurse #1 indicated ed leaving the ed pad. Nurse #1 shift CNA's had at they had found brown rings during start of the evening				ed lat ty ty ee, staff r ese r y
	the DON of the all indicated she did soiled sheets, but what the CNA's to indicated the CNA found brown rings sheet.	egation. Nurse #1 not go to look at the she did believe lld her. Nurse #1 s's reported they had			The CQI tool for abuse staff interview and abuse prohibition and investigation will be utilized weekly x4, and monthly x6 Findings from the CQI proce will be reviewed monthly and an action plan will be implemented for threshold below 95%.	ss

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION OU			(X3) DATE SURVEY COMPLETED	
		155135	A. BUILDIN B. WING	\G		01/18/	2013
NAME OF B	DOWNER OF CLIPPINE			ΓREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER			1510 CLINIC DR				
WESTVIE	EW NURSING AND	REHABILITATION CENTER	BEDFORD, IN 47421				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		II		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)	
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			AG	CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		COMPLETION DATE
	allegation occurred on a Friday and						
	she was not made aware of it until the						
	following Monday. The DON indicated						
	she was made aware of the						
	allegations by an "Employee						
		Communication Form." The DON					
	ir	ndicated she questioned Nurse #1					
	and	Nurse #1 had reported to her that					
	:	she didn't see the brown rings but					
	s	second shift had reported it to her.					
	The	DON indicated Nurse #1 had told					
	h	er (the DON) that the second shift					
		aides had reported dried rings on					
	res	ident sheets to her (Nurse #1) but					
	1	they (the evening shift CNAs) had					
	cha	inged the soiled sheets. The DON					
	ind	licated she didn't remember if she					
	had	d ask who the evening shift CNA's					
	We	ere who made the allegations and					
	the	CNA's were not interviewed. The					
	Г	OON indicated she did discuss the					
		allegations with CNA #2 and she					
	b	ecame, "kinda of insubordinate at					
	the t	ime because she felt like she was					
	I	being picked on." The "Employee					
	Co	mmunication Form indicated CNA					
	#2 h	ad refused to sign the form." The					
		DON provided Resident #C's					
	Prog	gress Note dated 09/14/12 at 1:36					
	p.m.	, which indicated, "Area to coccyx					

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STATEMENT OF DEFICIENCIES		X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTIPLE C		(X3) DATE SURVEY		
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER: 155135	a. building 00		COMPLETED 01/18/2013		
100130			B. WING	ADDRESS STEW STATE OF SORE	01/10/2013		
NAME OF PROVIDER OR SUPPLIER			STREET ADDRESS, CITY, STATE, ZIP CODE 1510 CLINIC DR				
WESTVIEW NURSING AND REHABILITATION CENTER			BEDFORD, IN 47421				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX TAG	(EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)		PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE		
1716	resolved at this time. Area healed.		mo				
	Sca	Scar tissue remains." This Note was					
	signed by the ADON. The Director of						
		Nursing further indicated, the					
	allegation of neglect had not been						
		reported to the Indiana State					
		Department of Health.					
	A policy titled Abu	se Prohibition,					
	Reporting, and Investigation (not						
	dated) was provided by the DON on						
	01/14/13 at 10:00 a.m. The policy						
	indicated, "It is the	indicated, "It is the policy of American					
	Senior Communities to protect						
	residents from abo	use					
	includingnegled	tNeglect occurs					
	when facility staff	when facility staff fails to monitor					
	and/or supervise the delivery of						
	resident care and services to assure						
	that care is provided as needed by						
	the residents. Ne	glect occurs when a					
	facility fails to prov	vide necessary care					
	for resident, such	as situations in					
	which residents ar	re being left to lie in					
	urine or fecesA	ll abuse					
	allegations/abuse	must be reported to					
	the Executive Dire	ector immediately,					
	and to the residen	t's representative					
	within 24 hours of	the report. Failure					
	to report will result	t in disciplinary					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION 00		00	(X3) DATE SURVEY COMPLETED	
		155135	A. BUI B. WIN	LDING G		01/18/	2013
NAME OF P	PROVIDER OR SUPPLIER			STREET A	ADDRESS, CITY, STATE, ZIP CODE		
WESTVIEW NURSING AND REHABILITATION CENTER			1510 CLINIC DR BEDFORD, IN 47421				
(X4) ID			1	ID ID	ND, IN 47421		(X5)
PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX	PROVIDER'S PLAN OF CORRECTION		COMPLETION
TAG				TAG	DEFICIENCY)	DATE	
	action, up to and i	ncluding immediate					
	terminationIt is	the responsibility of					
	the Administrator/Director of Nursing						
	to report the abuse, or allegations of						
		nours to the Indiana					
	State Department	of Health"					
	This Foderal/state	ton in relation to					
	This Federal/state Complaint IN0012						
	Complaint invol12	.2120.					
	3.1-28(a)						
	0.1 20(u)						

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